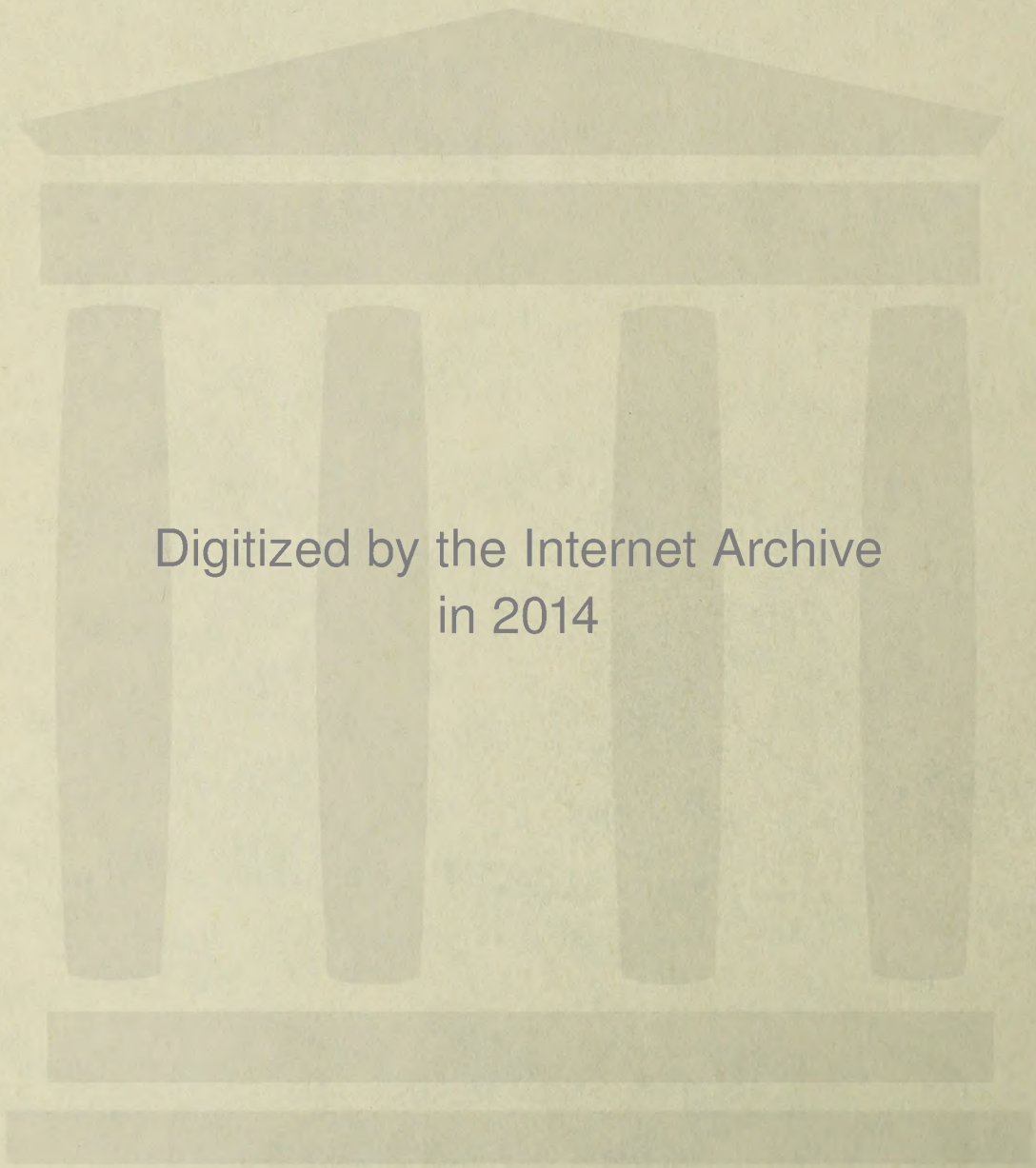

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A FOLLOW-UP STUDY OF SEVEN CASES DISCHARGED IMPROVED AFTER SHORT-TERM INTENSIVE CASEWORK TREATMENT IN A MENTAL HYGIENE CLINIC

A Thesis

Submitted by

Robert Marshall Rice, Jr.

(A.B., Bates College, 1952)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1954

School of Social Work
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CHAPTER I

INTRODUCTION

Purpose:

The aim of this study is to evaluate the holding power of short-term casework service in a psychiatric clinic. This study attempts to suggest answers to the following questions:

1. In what way does improvement seen by the clinic at discharge continue after a three year period without treatment at the clinic?

2. In what ways are casework treatment principles used in these cases?

3. What attitudes toward treatment are seen in the follow-up interviews?

Scope:

Short-term treatment is defined in this study as treatment lasting for less than six months. No attempt is made to consider the number of interviews as defining short-term treatment.[1] Only those cases meeting the following criteria were studied:

1. Cases seen for six months or less in treatment.

2. Cases treated by caseworkers only. In all cases, patients were seen by members of other disciplines for diagnostic purposes.

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1 See p. 62.

CHAPTER I

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3. Patients seen individually. (As opposed to group therapy, which is also a function of caseworkers at the clinic.)

4. Cases discharged in 1951.

5. Patients able to be seen by the investigator. (Out of an original fourteen patients, seven were available for follow-up interviews.)

Method of Procedure:

A qualitative analysis of treatment was made on the basis of clinic case records. The follow-up interviews were similarly evaluated and were conducted on the basis of the evaluation of the case records.

Limitations:

Since the investigator used a qualitative approach, the conclusions of this study are necessarily dependent on the subjective judgment of the writer. Also since any evaluation of treatment is based upon case recording, the caseworker's understanding of treatment process may also be a variable factor.

There was some variation in the process recording available in each case, although generally full recording was accessible. Since it was impossible to discuss the cases with the caseworkers involved, as they were no longer working at the clinic, the recording was the complete basis for observation

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of treatment.

Two of the cases in this study were carried by second-year casework students. Therefore, there was variation as to treating skills and experience. Four of the remaining cases were carried by one caseworker, so that also the study leans heavily toward evaluation of the work of this worker. One case was carried by another graduate caseworker.

With only seven cases, the conclusions of this study apply only to the particular situations cited, and cannot be generalized.

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With only seven cases, the conclusions of this study apply only to the particular situations cited, and cannot be generalized.

CHAPTER II

DESCRIPTION OF THE SETTING

Description of Briggs Clinic:

Briggs Clinic was formed in 1950 under the auspices of Boston State Hospital. It is felt that the clinic may eventually lead to a decreased admission rate to the hospital by providing a preventive mental hygiene program for individuals with emotional problems causing stress but which are not sufficiently severe to require hospitalization.

The particular method employed is outpatient individual and group psychotherapy. Therefore, individuals treated must (1) have problems that are emotional and psychological in nature, (2) have problems amenable to psychotherapy, (3) have problems that necessitate minimal environmental manipulation.[1] Specific considerations in accepting an individual for treatment at the clinic are as follows:

1. The patient's financial resources. Treatment is limited to those falling within a moderate income group.[2] Moderate fees are established, dependent on the patient's income, "instituted out of respect for the patient's feelings of independence, self-respect, and accomplishment,"[3] except among

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2 Ibid., p. 42.

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the lowest income group which is treated without charge.

2. "The patient must fall between the age range of sixteen to fifty-five years."[4]

3. "The patient must not be in current psychiatric treatment elsewhere."[4]

4. "Patients suffering addiction to alcohol or drugs will not be accepted."[4]

5. Veterans with service-connected psychiatric difficulties are not accepted."[4]

The clinic is not an out-patient department in the usual sense, since it does not work primarily with patients who have been released from Boston State Hospital.

The full-time treatment staff is small, consisting of two social workers, a clinical psychologist, and the directing psychiatrist. This small group is augmented by a variable number of part-time therapists which include second-year student social workers, hospital resident physicians, hospital staff physicians, and others whose training and experience, qualifications and interests qualify them in the eyes of the director for the practice of treatment. The small number of permanent staff members leads to a certain ease of collaboration which brings about informal interdisciplinary

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interactions, thus adding to formal staff functions.[5]

Although this study deals only with the formal treatment interview material, it is the opinion of the clinic that this interview should not be the only therapeutic experience which the clinic offers, and feels that a "combined therapeutic atmosphere" should be enacted from the time the patient first enters the clinic.[6] A warm, friendly atmosphere is strongly encouraged by all staff members, whether or not professionals.

Although both group and individual psychotherapy is offered at the clinic, to the present time, individual treatment is the predominant method used. Also, although there is no particular frequency of time set for interviews, almost all patients in individual treatment are seen one hour a week, except in rare instances.[7]

In a recent survey of results of clinic treatment, it was found that in the first three years of the clinic's operation, 61.6 per cent of the patients treated at the clinic had improved in the estimation of the clinic.[8]

This figure is related to all patients seen after diagnosis

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5 Tirzah Stein, "The Collaborative Approach in the Process of Intake at Briggs Clinic," pp. 43-44.

6 Briggs Clinic, op. cit., pp. 3-7.

7 James Mann, "Annual Report of the Briggs Clinic, July 1, 1951--June 30, 1952," p. 2.

8 Max Day, "Annual Report of the Briggs Clinic, July 1, 1952--June 30, 1953," p. 7.

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in treatment interviews, regardless of the time span of treatment. However, in a sense, the clinic considers itself as always having a short-term goal, since it does not offer the inclusive sort of therapy extended in psychoanalysis.

> In any case, we should not delude ourselves into thinking that we have effected radical personality reorganization. The fact is that such reorganization is not always a necessity. Too often, we tend to ignore or under-estimate the reparative capacity of a patient after he has been given some small amount of help. A high degree of self-repair following helpful stimulus on our part can be found in all varieties of emotional illness, including the psychotic of any diagnostic category.[9]

History of Briggs Clinic:

Although Briggs Clinic at first operated in the buildings of Boston State Hospital, shortly after its opening it moved to the George Robert White Health Center. During the time the studied patients were in treatment, shortly after the move, there was a long waiting list for treatment as a result of increased applications.[10]

Since the clinic was relatively young at this time, there was a certain enthusiasm among the staff. The director felt that this had a helpful effect in total treatment activities of the clinic.[11]

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9 Briggs Clinic, op. cit., p. 30.

10 James Mann, op. cit., p. 1.

11 James Mann, "Annual Report of the Briggs Clinic - July 1, 1950--June 30, 1951", p. 3.

Approximately 40 per cent of the clinic's patients were self-referred, which seemed to show a certain integration with the community and the clinic.[12]

The Role of the Social Worker Giving Treatment at Briggs Clinic:

Briggs Clinic uses the social worker directly with the patient in treatment. In fact, it has been noted that the greatest amount of treatment is carried out by the social work staff.[13] Such treatment is carried out with a team approach, using the psychiatrist and psychologist in consultation. Professional social workers are supervised by the director-psychiatrist, while social work students use these trained social workers as supervisors. Besides formal supervisory activities, the clinic offers an inclusive conference program, involving case presentation by various staff members at regular intervals, in which social workers are involved for six hours during a typical week.

Since members of all disciplines are involved in treatment, perhaps the greatest differentiation of function between staff members is involved in the intake procedure, when specialties are used as such in learning about the new patient,[14] although some slight overlapping of function seems

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12 Mary Day, op. cit., p. 4.

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to occur here also.[15] However, in actual treatment, the disciplinary classifications again break down, to a greater extent, and it becomes difficult to separate the function of the social worker from that of any other therapist. Much of the process practiced by members of all clinic professional staff members is identical.[16]

However, certain considerations have been given to differences in therapy as practiced by members of different disciplines.[17]

> Variation will occur when one considers the level on which each worker will operate, beginning at the point where the nature of the patient's relationship to the therapist and to other important figures of his present and past life appears for exploration. The social worker remains, at all times, on the level of the patient's conscious perceptions through all periods of the patient's life and experiences. The psychologist, by virtue of his further training in understanding and appreciating unconscious mechanisms, will move further into some areas of the patient's conflicts which are unconscious (perhaps pre-conscious) but not yet distorted by unconscious elaboration or condensation. The psychiatrist, with adequate training, may probe all significant unconscious impulses and ideas significant in the sense of probing those areas of the unconscious mental life that have direct relationship to the current emotional problem that brings the patient to the clinic. All three disciplines focus their activities on the presenting problem of the patient. The social worker deals with immediate derivations of the presenting problem on the

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15 Ibid., p. 41.

16 Manual of Practice and Procedure," op. cit., pp. 24-33.

17 Ibid., pp. 29-30.

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15 Ibid., p. 41.

16 Manual of Practice and Procedure," op. cit., pp. 34-35.

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conscious level. The psychologist and psychiatrist in addition to these, will search for the more remote derivatives of the presenting problem.

The latter statement is somewhat modified in practice. It is extremely difficult to always differentiate the degrees of conscious awareness for the patient as mentioned above. Then too, there are differences in ability and experience by staff members which lead to differences in the depth of the work done. However, this statement points out a trend in focus differentiation among the clinical team. As a rule, the social worker operates at a level of consciousness with the patient in terms of insight development.

The social worker at Briggs Clinic does a minimum of environmental manipulative work. Cases admitted to the clinic are chosen to require a minimum of environmental manipulation.[18] Therefore, the social worker's procedure leans heavily toward skills used in the interview, rather than using socio-environmental techniques outside of the interview situation.

In relation to this, the social worker usually works with only the patient as an individual, as might be contrasted with other casework settings where families are treated as units.

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CHAPTER III

DEFINITIONS

Two considerations in the following case material analysis are those of "treatment procedure" and "improvement." In order that these terms may be understood in relation to this study, an attempt is made here to define these terms.

Treatment Procedure:

Since terminology in casework is as yet not standardized, it is felt that a particular classification should be used in defining treatment procedure. Therefore, Dr. Edward Bibring's classification will be used.

This classification uses the term "principles" to mean those psychotherapeutic methodologies involved in any therapeutic situation, whatever the "technique" might be (casework, psychoanalysis, play therapy, etc.)[1] As a result of this definition,

> One can sometimes speak of a hierarchy of principles, since in certain combinations one or the other of the principles frequently represents the main principle to which all others are more or less subordinated.[2]

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The following remarks were collected both from Dr. Bibring's published remarks and also from unpublished class material from a course offered at Boston University School of Social Work. The five classifications used[3] are defined as follows:

1. Suggestion: Conveyance, directly or indirectly, of beliefs, attitudes, and feelings to the exclusion of logical thinking, by the use of archaic attitudes by the client or patient toward the caseworker or therapist. Therefore, the worker makes use of the ideas of power or wisdom which the client may have invested in his attitude toward him. In such a situation, the worker takes over the role of the patient's or client's psychic functioning, within a positive transference situation with an authoritative base.[4]

2. Abreaction: Expression of pent-up emotion. This principle almost always occurs in relation to other effects, since it is not curative in itself, but rather is an aid to other therapeutic principles in diminishing the effect of the feeling expressed, providing evidence of it, and in facilitating the integration of the emotion after suppression or repression. Therefore, as a curative process, this principle cannot be the main force in a case of lasting movement.[5]

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3 Ibid., p. 258.

4 Arthur F. Valenstein, op. cit.

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3. Manipulation: "Mobilizing and utilizing certain emotional systems existing in a given patient or client for the purpose of achieving an adjustive change."[6] This principle may be positive, or enhancing a given attitude, negative, or diminishing a given attitude, or experiential, offering a constructive learning experience.[7]

4. Clarification: The development of insight for the patient or client.[8]

> We clarify the patient's feelings, attitudes, his conscious personality patterns, and behavior patterns as well as the interrelation between different attitudes and feelings. Clarification consists also of the separation of objective reality and subjective meaning.[9]

5. Interpretation: The development of insight for the patient or client toward his unconscious personality patterns.[9] "Interpretation refers to the exposition of repressed material of the unconscious in a dynamic sense."[10]

In any given case, it is recognized that a number, if not all of these principles, are in effect, so that it seems necessary for the purposes of this study to consider mainly those principles which are most involved in that case.

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6 Marion Kenworthy, op. cit., p. 255.

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Improvement:

In this study, "improvement" is used in the same sense as positive movement. It is not within the scope of this study to determine an exact definition of the factors involved in positive movement. In a recent study, it was seen that the "determinants of movement are multiple and complex."[11] Movement might well occur as a result of influences completely outside of the treatment situation, particularly over the period between the end of treatment and the follow-up interview. This variable probably cannot be fully understood in this study, although some allowance for it will be made when outside factors can be seen as influential.

Hunt and Kogan have developed a scale by which movement in social casework may be measured.[12] The approach here is quantitative, and therefore cannot be adapted for the purposes of this qualitative study. However, in the development of the scale, the authors originally considered a six-point list of categories of movement, but for the purposes of the development of the scale, dropped the last two points.[13]

These original points are listed here, as follows:

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11 Malcolm G. Preston, Emily H. Mudd, and Hazel B. Froscher, "Factors Effecting Movement in Casework," Journal of Social Casework, 34: 111. March, 1953.

12 J. McV. Hunt and L. S. Kogan, Measuring Results in Social Casework: A Manual in Judging Movement, 64 pp.

13 J. McV. Hunt, "Measuring Movement in Casework," Journal of Social Casework, 29:346-347, November, 1948.

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13 J. Mcv. Hunt, "Measuring Movement in Casework," Journal of Social Casework, 29:345-347, November, 1948.

1. Changes in adaptive ability or efficiency.
2. Changes in disabling habits and conditions.
3. Changes in attitude or understanding as evidenced from the client's verbalizations.
4. Changes in the environmental situation.
5. Prevention of deterioration.
6. The estimated permanence of changes.[14]

Two comments are useful here. It is noted that the last two categories, although dropped from the movement scale, seem to be involved with the work of any follow-up, as opposed to a study of the case recording per se. Also, it is noticeable that an attempt to draw out those factors in movement that can be quantitatively measured has been made here. However, these points are useful in partially establishing basic qualifications for movement as examined in this study.

Since this study is qualitative, it is possible to be more flexible in approach to a definition of movement than might be necessary in a quantitative approach, such as the movement scale. The Hunt study provides a basis which this writer expanded for qualitative study.

"Improvement", or "movement" in this study is defined in relation to the problem presented at intake. Areas of movement are similarly defined by the presenting problem in comparison with any adjustmental change providing more satisfying,

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14 Ibid., p. 346.

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6. The estimated permanence of changes.[14]

Two comments are useful here. It is noted that the last two categories, although dropped from the movement scale, seem to be involved with the work of any follow-up, as opposed to a study of the case recording per se. Also, it is noticeable that an attempt to draw out those factors in movement that can be quantitatively measured has been made here. However, these points are useful in partially establishing basic qualifications for movement as examined in this study.

Since this study is qualitative, it is possible to be more flexible in approach to a definition of movement than might be necessary in a quantitative approach, such as the movement scale. The Hunt study provides a basis which this writer expanded for qualitative study.

"Improvement", or "movement" in this study is defined in relation to the problem presented at intake. Areas of movement are similarly defined by the presenting problem in comparison with any adjustmental change providing more satisfying

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[14] Ibid., p. 316.

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CHAPTER IV

PRESENTATION OF THE CASES

The cases are presented in three sections. The first section consists of cases one through four which seem to show at least one clear-cut area of improvement. The second section consists of cases five through seven which seem to show either less improvement or a less clear-cut area of improvement. The third section is a schematic presentation of the diagnoses, primary treatment principles used, and improvement in each of the seven cases.

SECTION I - CASES WITH CONTINUING IMPROVEMENT

Case 1:

Diagnostic Considerations:

At intake, this 41-year-old housewife presented a nervous, tearful appearance. She came to the clinic self-referred, with the precipitating factor of difficulty in her marriage. She had been married twelve years to a man four years younger than she, and at present was living with him and her two daughters, ages four and eight, in a four room apartment. The husband ran a drug store, which had had financial problems since his ownership.

For four months, the patient's difficulty with her husband had become intense. Previous to this time, the patient described her husband as a dependent person who had objected strongly to having children. In this recent period, however, the patient's husband had been extremely hostile to her, accusing her of being suspicious, domineering and possessive. The husband was seeing another woman, and was threatening to leave the home. At the same time, he was refusing to give the patient money for weekly expenses.

The patient had strong feelings of guilt, feeling

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The patient had strong feelings of guilt, feeling

that she was at least partly to blame for the situation, and was coming to the clinic in order to help herself to change to please her husband.

Sexual contact in the marriage had been infrequent from the start, but since the patient's husband had been having extramarital relations, sexual relations had been less frequent.

The patient's husband was not aware of her contact with the clinic, and the patient stated that there was little likelihood that her husband would agree to come to the clinic himself at this time.

The patient received a diagnosis of "Reactive depression, moderate in a difficult marital situation," and a treatment plan was formulated. It was clarified at the start that no guarantee could be made that the marriage could be saved, but rather that the clinic could help diminish the patient's emotional reaction to this difficult situation so that the patient might be better able to cope with it. It was planned that the caseworker would help to support the patient through this difficult period, since the psychiatrist felt that the patient was essentially a "realistic person" and would not need more intensive help.

Description of Treatment:

The patient was seen individually by a female staff caseworker in six interviews over a period of a month and a half.

Originally, the patient considered not continuing in treatment, since she felt that home conditions had improved somewhat. Her husband was "giving her another chance" and the patient was trying to "bend over backwards" for his approval. The patient wept about this. At this point, the patient was refusing to discuss divorce with her husband, although he was bringing this up often. In the first interview, the patient was able to discuss some of her feelings of disappointment in her husband, and discussed the circumstances around her marrying. The patient married late, after the death of her mother when "there was nothing to hang on to." The patient's husband was very close to his own parents, and the patient felt he needed a mother more than a wife. The patient realized that actually, the marriage had not been happy since the wedding, as a result of the competition the patient had felt in

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relation to her husband's mother.

Through the next two interviews, the patient tended to deny her problem, and seemed more relaxed in the interviews. Her husband stopped his extramarital relations and as a result the patient was less critical of his dependent characteristics. The patient again wondered whether to continue clinic appointments. Finally it was pointed out by the worker that the patient seemed tense underneath her facade of contentment. The patient realized that she had a tendency to deny her problem, and elaborated on this in relation to her husband, her mother, and now the worker. The patient realized that this pattern had been influenced by her mother's sickness, during which time the patient had felt unable to tell her mother about her feelings. Finally, the patient compared her husband angrily with her mother, saying that she wanted to be able to express herself, rather than to have to hold in her feelings. Immediately following this, the patient cancelled an appointment.

In the next two interviews, the patient discussed her brother's coming. The patient felt that her husband's parents were "hounding" him, and were thus driving him away from her. The patient discussed returning to work (she was a trained pharmacist) since she felt unloved in her marital situation. The worker supported this move, discussing the cause of the difficulty as the husband's problem. The patient's brother had visited the home to act as an impartial mediator and had felt that the husband should accept therapy. However, the husband would not agree to this unless, after having a course of treatment, if he should still want a divorce, his wife would agree to this. The patient found this difficult to do. The older child resented the husband being out of the home, and the patient had forced the husband to agree to spend more time with the children. Because of this reaction by the children, she again found it difficult to face a possible divorce. However, she was able to express a great deal of hostility toward him in interviews for his demands on her, and expressed her wish to be a man because of her feeling that she could handle her husband's work better than he. After expressing this, she saw that she might be more helpful to her husband at his work, by helping him in the drug store.

In the last interview, the patient had a composed attitude, in spite of the continued hostility toward

her husband. She discussed some of her memories, and saw that she had always had to be "adequate". Her mother depended on her, so that she was never able to depend on someone else. She had been concerned about others' opinion of her since her adolescence, when she was quite obese, and was ridiculed about this. The patient realized that her own feelings of inadequacy had intensified her reaction to the unfortunate marital situation and began to make constructive plans for further interests, notably a public speaking course, and was able to consider independent working and self-support.

The patient finally called to terminate, telling the worker that she was working at the drug store in much of her free time, and as a result could not continue her clinic contact. As a result of her increased activity, some of the tension in the home was lifted.

Discussion:

The patient seems to have a great degree of ego-strength, but the problems of earlier periods, notably those around dependence and sexual identification, have been intensified by an extremely difficult reality situation.

The caseworker offered the patient an experience (manipulation), that of being somewhat dependent on the worker, with the worker accepting her in her dependence. Abreaction was used as a tool to make the experience an emotional one, while clarification and suggestion were used in supporting the patient's outside interests. The patient learned through experience that it was acceptable and necessary to express her feelings, and that she need not have feelings of guilt around the marital situation, since the caseworker continually clarified that much of the problem was caused by the husband.

The patient was at first ambivalent about this experience,

her husband. She discussed some of her memories, and saw that she had always had to be "adequate". Her mother depended on her, so that she was never able to depend on someone else. She had been concerned about others' opinion of her since her adolescence, when she was quite obese, and was ridiculed about this. The patient realized that her own feelings of inadequacy had intensified her reaction to the unfortunate marital situation and began to make constructive plans for further interests, notably a public speaking course, and was able to consider independent working and self-support.

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and cancelled an interview after an abreactive period. However, she was able to come back for a short time, partly as a result of increased pressure at home, and partly because of the worker's acceptance. It seems that as a result of the high degree of ambivalence this patient had toward any dependence on the worker, she was never able to work out her problems, except on a very superficial level.

However, there are areas of movement here. The patient has become able to express her feelings more easily and therefore has become more free in seeking new constructive experiences and plans. She has considered independent action. Some of the relationship between the patient's reactions to her husband, and her earlier reaction to her mother has been clarified. Through the therapeutic experience, the patient seems to have become comfortable enough so that her independent needs have become dominant in relation to treatment, and a greater degree of integration has come about within the home situation.

Follow-up Interview:

> The patient is seen at the clinic, after she has answered the investigator's letter, saying that because of the nature of her problem, she wanted to be interviewed out of the home situation.
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> Throughout the early part of the interview, the patient weeps controlledly. The patient is still living with her husband and daughters, although the marital situation is essentially unchanged. The patient's husband still periodically threatens to leave her, and still is extremely hostile. Although the extramarital affair has not continued, the husband now has a drinking

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problem, and has been on "binges" away from home for as long as a six-week period. He is irritable with the children, although there is at times a good deal of affection between himself and the children. The patient tells this quite easily, and is able to express her feelings of anger at her husband without a great deal of difficulty.

Because of the relationship between the daughters and the husband, the patient has decided not to break up the marriage.

The patient feels that she is better able to handle her problems now. She is able to keep occupied by a number of club activities and her work at the drug store, which she now does frequently. Also, she feels that since treatment, she does not feel so guilty over the situation, and on occasion is able to talk it out with her friends, whereas before, she could not talk about it with anyone. The patient states that "treatment helped me to express some of my anger, and not feel wrong in doing it," and relates that she has had difficulty in expressing feelings throughout her life, because of sickness in her family.

It is still difficult for the patient to express her anger directly toward her husband, since this adds to the difficulty of the situation. The patient seems to recognize her anger, however.

The patient's ambivalence concerning dependency is still evident in her remarks about her thoughts about leaving her husband, and she states both her feelings of wish to leave, and fear of it, in terms of her inability to care for the children properly financially, or without her husband.

Although the patient still has strong feelings concerning the situation, she does not feel overwhelmed as she did when applying for treatment.

Discussion:

Although the patient continues to have a problem with her own ambivalence around dependency, it also seems evident that she is handling her problem better now than she had originally.

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Discussion:

Although the patient continues to have a problem with her own ambivalence around dependency, it also seems evident that she is handling her problem better now than she had originally.

Although it is probable that a good deal of denial, which seems to be a characteristic defense for this patient, is involved in her statement, it is also evident that the patient feels comfortable enough with her feelings to discuss and express them easily in the interview, lending credence to her statement that she is able to discharge her feelings outside of the home.

The worker's support of her outside interests evidently was helpful, since such interests are much more widespread than before, and the patient has been able to gain satisfaction from her work as a pharmacist, which the patient returned to while in treatment.

The patient's insight into some of the meaning of the reaction to her husband is probably still effective. She recognizes some of the relation of her past life, and her need to hold in feeling, with the situation she felt herself in at the time of treatment.

The patient seems to be operating at about the same level of improvement as was seen at termination of treatment, since she has developed outside interests, is relatively relaxed in the situation, and feels more comfortable with her own feelings of hostility, which she can express, although somewhat indirectly.

Case 2:

Diagnostic Considerations:

This 28 year old man was referred to the clinic after

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This 28 year old man was referred to the clinic after

being seen at a Veterans' Administration Regional Office, since this agency did not feel that his problem was service-connected, and therefore could not treat him. He had had submarine service during the war, and had some combat experience. He was living at present with his father and younger brother in a low-income housing area, and was not married. His religion was Roman Catholic.

The patient presented his problem as "a feeling of inferiority" which he felt had started at the time he was in junior high school. This had continued to become more intense, until at this time he was afraid that he was becoming psychotic. After his discharge from the Navy in 1945, he had been restless and unable to stay at any one job over a period of time. He had also developed indigestion and headaches which occurred after he made what he felt was a "stupid remark or act."

The patient's mother died when he was eight. The patient was able to express anger toward his father, who the patient felt had never "controlled the family," and had seldom helped the patient, so that the patient felt he had "always been on my own."

The patient had had one homosexual experience about three years ago, and seemed to have strong guilt feelings about this.

Recently, the patient's second brother (living outside the home) had entered a mental hospital. This seemed to have intensified the patient's present difficulty.

The latest thing that had added to the patient's difficulties was his feeling that people were laughing at him because "I look so sad."

The patient was diagnosed "Schizoid personality," and it was recommended that he receive psychological testing before treatment "to evaluate the intensity of his homosexual conflict as well as to give an assessment of his own body image." However, this was not done, since the patient did not actually enter treatment until about three months after intake. He spent this time on a religious retreat at a monastery.

A treatment plan was formulated to explore the patient's feelings of inadequacy, particularly in relation to being a man. Similarly, it was felt that the

patient's relationship to his three sisters (now married) who had acted as mother-figures to the patient after his mother's death should be explored. It was particularly recommended that the patient work with a female therapist.

Description of Treatment:

The patient was seen in eight treatment interviews over a three-month period.

Throughout the treatment process, the patient showed a great deal of ambivalence toward the worker, a female staff caseworker. At the first interview, the patient questioned whether or not he would continue, and he continued this questioning throughout the contact.

At first, the patient related his feelings of inadequacy in relation to other people, particularly women, and also expressed first his resentment of his family relationships which he characterized as distant, and then his feelings of loneliness which had been apparent to him throughout his life. The worker interpreted his difficulty in continuing treatment as related to his fear of women generally, saying that they made the patient feel weaker, while clarifying that this was the patient's feeling. This was coupled with a great deal of support.

The patient, with the help of the worker, began to see the relationship of his feelings of ambivalence to the worker and his feelings toward his sisters, and then felt guilty at his resentment of them. The worker supported him, saying that he under evaluated himself in relation to his family.

By the fourth interview, the patient related his sexual fears. He was afraid of becoming sexually perverted, and told the worker of his homosexual experience and his frequent masturbation with accompanying heterosexual fantasies. The worker was then able to talk about his family relationships--the fact that his sisters had never been able to take the patient's mother's place. He had not felt accepted by them, and therefore had withdrawn from a strong positive relationship with them. He mentioned an effort to take over a male role in the family, fulfilling a function of his father, when he had been derided, and had felt extremely anxious as a result. With this admission, the patient

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began to speak guardedly of some of his good qualities.

The patient got a job after this interview, but continued to have difficulty with social contacts. The worker discussed this in terms of his family relationships, and the patient's relationship with her. With difficulty, the patient could see that the worker and his sisters had shown interest in him. This was followed by his telling about a number of heterosexual intercourse episodes, none of which had been satisfying for the patient. The patient continued to test his own sexuality in this way. Again the patient talked about his fear of insanity, since one of his sisters had had a psychotic episode long before treatment, and the patient wondered if his family as a whole was "inferior." However, with encouragement by the worker, the patient was again able to express more positive feelings about his own abilities. In this interview (the fifth hour) the patient was visibly relieved.

Subsequently, the patient continued to bring out guilt over his sexual feelings, and was able to tell the worker that this was involved in his feelings toward her also. However, he saw that more than sexual relations, he wanted love from a woman.

In the last two interviews, the patient was more composed in attitude. He realized his own feelings were involved in his ideas that others belittled him--that this was actually his own feeling of inadequacy being expressed. His social life continued to be narrow, but he felt more comfortable with himself and his own feelings. There was a lingering fear of others thinking him a homosexual, but this too was less intense. The patient saw that his going out with prostitutes was part of his own feeling of not being good enough for a more acceptable woman. The patient also had guilt feelings over his lack of religious faith. However, in spite of these difficulties, he was able to accept gracefully a compliment which the worker gave him.

The patient finally closed treatment as a result of plans made for a trip to Italy, his father's homeland, with his father. The patient was looking forward to this, and stated that his feelings of guilt were no longer so intense. He felt that he needed "practice" in making social relationships, and intended to return if his feelings returned to their previous intensity. The caseworker felt that the patient was notably more flexible in his ideas, and was less self-depreciating.

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Discussion:

The patient shows a great degree of psychiatric pathology in almost all areas. The worker focused on the way the patient related to her, and in so doing clarified his feelings toward other people. Also significant in the treatment process were abreaction and manipulation.

The patient continued to be ambivalent toward the case-worker throughout the contact, and much of the insight gained was on an intellectual level. However, the patient gained a more realistic self-image, and was able to find some of his own strengths. Generally, through the contact he seemed to become more comfortable.

Again, further pathology can be seen, particularly in the area of sexual identification, which still seems to be extremely ambivalent. However, the patient seems to be greatly improved in that he is working and is able to adjust to his family situation in a healthier way. It is particularly noticeable that the patient has gained in working through some of the crippling guilt that he was feeling at intake.

Follow-up Interview:

As a result of a letter, an appointment was made at the patient's home for the investigator to interview the patient. At the investigator's arrival, the patient says that he was not aware that the investigator was coming tonight, although he remembers the letter. However, he has forgotten the date mentioned.

The patient still lives at the same address with his father, who is not at home when the investigator calls. The home is in a run-down section, and the

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The patient still lives at the same address with his father, who is not at home when the investigator calls. The home is in a run-down section, and the

apartment is not well kept, with ashes on the floor, unmade beds, etc. The patient has a very guarded attitude in the interview, asking a number of questions about the investigator's youth, experience, etc. It is particularly noticeable that the patient consciously avoids almost any mention of sex.

Social life for the patient is markedly more active. He is planning to go out with some men friends the evening that the investigator calls. He goes out on dates, but "I can't get married because something always happens." Now, another brother has had a psychotic episode, and is at a state hospital, and therefore the patient feels needed at home. Evidently, the patient now feels a great deal of responsibility in the home, and was able to take a leadership role in making arrangements for his brother's hospitalization. (He had called the clinic about this a few months previous to this interview.)

The patient feels that he was helped by his contact with the clinic by "talking out my problems and gaining understanding." At the time he was treated, the patient felt "nervous and upset," and although he still tends to be moody, he feels this is no different than most people, and certainly not as intense a feeling as when the patient was in treatment. He handles his moods by recreation; if he feels this way he goes to a dance or a movie, and finds this is helpful.

The patient feels that his therapist told him about the relationship of his depression to his family relationships. He tells about angry feelings about the demands that his family place upon him but on the other hand justifies this by saying he can't do enough for them.

In recalling treatment, the patient says that although he continued to have rather intense anxiety after leaving treatment and during his trip to Italy, his feelings became less intense as time went by, and he feels that this gradual lessening of intensity was a result of treatment, in that he used what he had learned in treatment. The emphasis here is upon his own ability to handle his own feelings.

The patient still has some question about the weakness of his family as a whole, and asks the investigator if this is possible. At the same time, he tends to have a rather philosophical, religious approach to his feelings at the end of the interview.

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Social life for the patient is markedly more active. He is planning to go out with some men friends the evening that the investigator calls. He goes out on dates, but "I can't get married because something always happens." Now, another brother has had a psychotic episode, and is at a state hospital, and therefore the patient feels needed at home. Evidently, the patient now feels a great deal of responsibility in the home, and was able to take a leadership role in making arrangements for his brother's hospitalization. (He had called the clinic about this a few months previous to this interview.)

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The patient feels that his therapist told him about the relationship of his depression to his family relationships. He tells about angry feelings about the demands that his family place upon him but on the other hand justifies this by saying he can't do enough for them.

In recalling treatment, the patient says that although he continued to have rather intense anxiety after leaving treatment and during his trip to Italy, his feelings became less intense as time went by, and he feels that this gradual lessening of intensity was a result of treatment. In that he used what he had learned in treatment. The emphasis here is upon his own ability to handle his own feelings.

The patient still has some question about the weakness of his family as a whole, and asks the investigator if this is possible. At the same time, he tends to have a rather philosophical, religious approach to his feelings at the end of the interview.

Discussion:

Much of the pathology that was seen in treatment is still seen in this interview. The question that the patient still has about his own ability (manhood) and the defensive, guilty attitude about sexual matters, point toward the problems of sexual identification as still being a factor in the patient's life. Also, the moodiness may indicate more anxiety than the patient wanted to discuss. Then too, the ambivalence toward his family seems evident.

Although the basic psychological problems seem strikingly similar to the problems seen at intake, it is also notable that the patient seems to be able to handle these conflicts in a more realistic way. The patient has made great strides in the family situation, although he seems to be ambivalent in this area. However, the dominant feeling seems to be positive. It is particularly striking that the patient is not becoming overwhelmed by the present situation of the ill brother, which is so similar to the precipitating situation three years ago.

In the period following treatment, it would seem that the patient has strengthened his defenses, and thus diluted the angry, anxious and guilty feelings. One typical, but new defense is the intellectualization process.

Evidently, some insight into the patient's feelings toward his family was gained, although the patient seems ambivalent and somewhat guilty about the resentment that he feels.

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Case 3:

Diagnostic Considerations:

This 42 year old railroad maintenance worker came to the clinic with the symptoms of pounding heart, indigestion, and exhaustion following the birth of his eighth child. His income was quite low, and with medical problems that his wife had, there were some very real financial difficulties for the patient.

The patient mentioned his resentment of his second child, a boy, whom he characterized as "lazy," and whom he contrasted with himself as a boy, when he had to work on a farm. He had always been confronted with responsibility, since he was an only child and his father had died when the patient was 18 months old.

In 1939, the patient was hospitalized for five months as a result of poliomyelitis. Therefore, he accumulated a number of debts, and was trying to pay these by working overtime, getting very little sleep. Since this time, the patient had had strong fears of dying.

The patient's mother was also living with the patient until about a year ago, when she left after dissension with the patient's wife, a woman three years older than the patient. The couple had been married for 19 years at this time.

The patient impressed the psychiatrist and the social worker at intake with his pride and wish to minimize his difficulties, seeming ashamed and apologetic in speaking about them.

The diagnosis was "Psychoneurosis, anxiety state." The treatment plan was to help the patient to ventilate about his real difficulties. If such ventilation was supported, it was felt that the patient could verbalize his wish to die as an escape from the difficulties he was facing. Thus, this wish might be expressed in a more integrated way.

Description of Treatment:

The patient was seen for five and a half months by a female staff caseworker, in a total of ten interviews. In the first interview, the patient denied all feelings of discouragement, and could only verbalize

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the anger he felt at the second son. However, by the second interview, he was able to say with feeling that he was tired of providing for others, and wished to be cared for himself. This occurred after considerable encouragement by the caseworker.

This period resulted in an almost immediate lessening of symptoms. However, he still retained much of his anger at his second son, and expressed the idea that his dependency wishes were unmanly. However, he was able to return to work, although he was refusing overtime. He began to show hostility to a number of figures that were not particularly close to him--a college man in an accident he read about in the newspapers, and a rather distant acquaintance. Again the patient expressed his wish for less responsibility, this time less directly, by saying that he wished he was not "so honest and responsible."

The patient continued to be free of his physical symptoms, and was no longer troubled with his fears of death. The worker was able to offer a part-time job to his daughter, to help the patient with his finances. The patient was able to make positive movement in his job by first formulating some plans to save himself time, and finally by a substantial job promotion.

During the eighth and ninth hour, the patient virtually repeated his earlier experience, verbalizing his anger and fear at his responsibilities, but with the encouragement of the caseworker he was again able to talk of his own dependency wishes.

The patient terminated at the tenth interview, having had little recurrence of his physical symptoms or his fear of death. By this time the patient gave an impression of a great deal more control and a more relaxed attitude.

Discussion:

Abreaction seemed to play a large role in this patient's recovery. This was made effective by the worker's acceptance throughout the experience. Thus, manipulation was used to provide a corrective experience.

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This case seems rather remarkable in the simplicity of the process here. The patient's symptoms were markedly lessened after the second hour, in which he was able to express his forbidden wish for dependency.

There has been little or no insight development here, and yet the patient has made remarkable gains in a very short period of time.

This case seems reminiscent of the war neuroses, in its rapidity of process in therapy. The patient was overwhelmed by a very difficult situation, but showed a great deal of ability to handle his responsibilities.

The meaning of the patient's change in jobs, and the concurrent raise in pay cannot be underestimated. However, it is notable here that the actual change in the patient's pathology took place before the job change. Perhaps the decrease in the financial problem as a result of the new job was helpful in the patient's continuing progress. Similarly, the worker was able to manipulate the environment, so that added income might be possible through one of the patient's daughters. Most meaningful seemed to be the patient's repeated experience of telling the caseworker about his unfulfilled dependency needs.

The problem of the patient with his second son is left somewhat unanswered.

Follow-up Interview:

Although a letter had been sent to the patient

saying that the investigator would be calling, the patient was asleep when the investigator arrived, since he was to be working that night. He greeted the investigator warmly, saying that he "had forgotten that tonight was the night you were coming."

The patient lives in a large, rather run-down house, which seems overrun with children. The furniture shows much use. The children seem relaxed with the investigator, as do the patient and his wife, a pleasant, smiling woman. The bulk of the interview occurs with only the investigator and the patient, since the investigator asked to see the patient alone.

The patient is relaxed, and relates to the investigator easily.

After treatment, the patient went to a chiropractor, since he still suffered some indigestion, although this was less intense. There has been no return of the patient's fears of death. The patient praises the chiropractor as helping him, and it seems that he feels that he has received his greatest help from him.

Generally, the patient's life is much improved. He is now getting a higher salary, and although he has to work a great deal of overtime, he is able to relax on occasion, and speaks of his plans for a fishing trip in the spring. The patient has been symptom-free since about six months after clinic termination.

The patient speaks of his second son very warmly, saying that he is now going to a trade school, which he entered shortly after the patient was seen at the clinic, and mentions his son's successes in his school-work. The two now often go fishing together.

The patient feels that the clinic helped him, and characterizes his caseworker as "soothing." However, he feels that his increased pay, and the chiropractor's help were also important.

The patient can rather easily discuss his responsibilities and say that they are difficult for him, and that therefore he has to get away from the home on fishing trips on occasion. However, his problems have "never gotten me down to the same extent." The patient speaks enthusiastically and optimistically throughout the interview.

Discussion:

In terms of his social and psychic integration, the patient has made remarkable strides in a number of areas. His symptoms have not returned, and he is having less difficulty with his job and family adjustment.

Evidently, the patient has very little insight into the process by which he was helped. He gives little credit to his caseworker, beyond mentioning that she was helpful with her "soothing" manner, although he remembers treatment as a positive experience.

A number of events have diminished the stress situation. The patient is in a better financial-vocational situation. Evidently, some of the patient's dependency needs were satisfied in his relationship to the chiropractor. Thus, it is difficult to evaluate the role of treatment in the patient's continued improvement.

However, the patient seems to be able to discuss freely the difficulties of his responsibilities instead of using neurotic symptoms to express his dependency wishes indirectly. The patient, in recognizing these needs, has been able to satisfy them through a relatively fuller recreational life.

Generally, the patient's behavior illustrates a greatly improved adjustmental reaction, although the patient shows little insight into the treatment situation.

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Case 4:

Diagnostic Considerations:

The patient came to the clinic with considerable hostility toward her husband, although she felt that "all disagreements should be handled objectively." Generally, the patient's disappointment in her husband concerned his dependency and the lack of acceptance he showed for her friends.

The patient was living in a five-room apartment in a two family house with her husband and two children, the older being 10 years. She was 35 years old at this time.

Because of the patient's guilt and anxiety about her own hostility toward her husband, she tried to hold in her feelings, only to find that her husband sensed her anger, and quarrels occurred anyway. Two weeks before intake the husband had become intoxicated and had been very angry. At this time, the eldest daughter had seen her enraged father, naked, shouting at the patient. The patient's cousin's wife, who lived upstairs in the same building, heard the commotion and was instrumental in referring the patient to the clinic. The patient had uneasy feelings in her stomach whenever she thought about this incident.

Also, the husband made a great number of sexual demands on the patient, which she could not satisfy. This was another source of anger for him, while the patient fumed inwardly, knowing that her anger wouldn't solve anything.

The diagnosis of "Anxiety state, mild" was conferred. It was felt that it might be beneficial for the husband also to have treatment, but this plan was never successful. The treatment plan was "to clarify all disappointed and angry feelings with respect to her husband." It was felt that such clarification might eventually lead to further clarification in the area of the patient's feelings when she married.

Description of Treatment:

The patient was seen by a female staff caseworker in thirteen interviews over a six-month period.

During the first two interviews, the patient was extremely tense. She verbalized her hostility toward

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During the first two interviews, the patient was extremely tense. She verbalized her hostility toward

her husband, with ensuing guilt about her pushing him to be more ambitious when she felt he actually was looking to her for strength, since his own family relationships were never helpful to him. She wondered again if she should hold her feelings in or satisfy herself, and thereby hurt her husband. With exploration, it was seen that the patient did not hold her feelings to herself, but rather her feelings were expressed indirectly.

The patient then moved to discussing her feeling that she was not dependent enough for her husband--that actually he wanted a less aggressive woman. The patient saw that she tended to evade her husband's criticism, and felt that his judgment was of little worth. This led to a comparison of the husband to the patient's father. This was pointed out. Also, in this process the patient was able to see her father more realistically, after initially giving a very idealized description of him. Following this, the patient was able to have a temporary period during which she felt more appreciative of her husband. She described her feeling that she should be more dependent as a woman, but that she felt this was impossible for her. During this period, she felt, more realistically, that she and her husband could complement each other's characteristics.

However, by the sixth interview, the patient returned to her difficulty, and discussed in an intellectual way, solutions to her problem: 1) talking her feelings out with her husband, rather than remaining aloof, 2) developing outside work for herself in order to get away from the situation (the patient's husband would not allow this). The worker noted that at this point she was trying to give the patient the experience of being somewhat dependent upon her. The patient was able to state that she had had an abortion when she was first married, and although she had felt that this was for "logical" reasons, she saw that it was an expression of the anger she had felt toward her husband even at that time. She also saw that she had angry feelings toward her children that seemed to reflect her feelings of anger at her husband.

From this time to the end of treatment, the patient continually broke appointments, and therefore was seen infrequently. During this period, she showed hostility to the worker, denying any wishes for dependency. Before the ninth interview, she took fifty

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aspirins in a suicide attempt. The worker interpreted this as her wish for dependence, which the patient continued to deny, except on an intellectual level. The worker continued to focus on the patient's dependency wishes and the fact that the patient tended to ask for advice from her. The patient continued to deny her dependency wishes and angrily told the worker that coming to the clinic made her feel weak, which she resented.

At the same time, home relationships were eased. The patient became somewhat more accepting of her husband, and some of the tension was lifted when the patient took a part-time job.

The last interview occurred a month and a half after the twelfth interview. The patient was much more relaxed in the interview, and stated that because of the amount of work that she was doing, she had decided not to continue in treatment.

Discussion:

Evidently, the patient was unable to continue to explore her own dependency needs. Much guilt and anxiety were built up over this issue.

However, there were noticeable gains in the area of clarifying the nature of the patient's hostility, and ways of handling this. With the contact being rather broken at the end of the record, it is difficult to see how much help the patient actually received, although it is probable that she received understanding on an intellectual level. Particularly noticeable was the development of awareness that the patient's hostility was continuing to be expressed, in spite of her feeling that this shouldn't happen.

Also, the patient's general behavior in the interview and at home seemed to lose some of its marked tension, observable

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early in the contact.

The patient came to a more integrated understanding of herself in relation to her parental and present family, although the interpretive and experiential, manipulative program that the caseworker hoped to offer was never successfully completed. The patient seemed to have difficulty in the fundamental area of sexual identification in relation to dependency.

It might have been helpful for the clinic to have been working with the husband also, who seemed to have a rather serious problem himself, seemingly over his own sexual identification. In this sense, the patient was having a difficult reality situation which she interpreted and handled in terms of her own problem.

There may have been some movement involved in the hint of redirection of aggressive impulses by the patient in her working. The worker gave support to this, and at the end of the contact, the patient was getting some satisfaction out of a part-time job. It is uncertain from the material if this trend is to be continued.

Follow-up Interview:

> The patient is a very neatly-dressed, intelligent woman who sees the investigator at the clinic, at her request.
>
> She spends much of the interview time berating her husband angrily, telling of his various inadequacies. At the same time, the patient shows a great deal of intellectual understanding of his need to be cared for, and her need to control. Evidently, she is skilled in a number of areas, many of them masculine

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tasks such as wallpapering, boating, carpentry, etc., and is able to handle such situations better than her husband, who resents her interference in "my work," which the patient feels he does poorly. This often results in an authoritative attitude on the part of the husband, which the patient resents, but which she realizes is the result of her own tendency to belittle him. In the course of this discussion of the patient's marital relationships, it is still seen that there is a great amount of underlying hostility.

The patient feels that the personality difficulty between herself and her husband is impossible to mend, and therefore she has considered leaving him, and has made constructive plans for doing so. However, she feels that this would be difficult for the children, particularly the eldest son. She has discussed such plans with the children, but the son tends to want to avoid this. The patient's reaction at this point is one of ambivalence, and some irritation at the son. However, the patient continues to make plans for the break, and has made very concrete plans for self-support with a slight capital investment on her part. The investigator's impression of this is one of very careful and realistic planning, as the patient goes into detail about it. She is confident of her own abilities, having had extensive part-time work experience since leaving treatment. Her social activities have also increased. In discussing the problem of leaving her husband, she mentions remarriage as a frightening thought because of her anxiety about being dependent on an inadequate man.

In discussing the treatment process, the patient feels that the worker was "nice and intelligent" but questions how it helped her, feeling that the same problem with her husband still exists. However, she does discuss her own evaluation of the marriage in which she concludes that her own needs in combination with those of her husband are disruptive to this marriage, and credits both reading and treatment for help with such an evaluation. However, there is still some evidence of her original fear of dependency on the clinic, as the patient says that it was "humiliating, in a sense, to talk to a stranger about myself." However, the patient's husband had not wanted her to see the investigator, but she came anyway.

Discussion:

It would seem that the patient still has many areas of difficulty. She continues to be hostile to her husband, and perhaps some of this hostility is involved with her relationship to her son. The ambivalence over any dependence may still be strong, as evidenced in her reaction to treatment and the follow-up interview. However, as the patient discusses her activities, it is seen that she has learned to channel much of her aggression in a somewhat more acceptable way, although this is at times in opposition to her husband's needs, and creates more friction.

Evidently, the patient gained primarily in the area of intellectual understanding, and she is making plans in the light of this understanding, although both her own ambivalence about leaving her husband, and her son's feeling about leaving are hindering her action at the present time.

The patient herself feels that her anger and anxiety are no longer so intense as they were when she was in treatment, and this is probably due to some dilution of intensity of feeling as a result of her channeling her aggressive needs.

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SECTION II - CASES DEMONSTRATING LITTLE IMPROVEMENT IN THE FOLLOW-UP INTERVIEW

Case 5:

Diagnostic Considerations:

The patient, a 37 year old man, was employed as a truck driver. He was married, and had five children. The family lived in a comfortable suburban community, in a seven room house.

The patient came to the clinic shortly after a period of observation at a state hospital following a court charge of assault and battery and lewdness toward a six-and-a-half year old girl. At the time of intake, he was on six month's probation. The patient said that he was innocent of this charge, but "had to plead guilty to keep the little girl out of court."

The patient presented the problem of his relationship to his wife. He felt continually that she was rejecting him, although he felt that his own feelings were "too easily hurt." He mentioned that he felt rejected at very slight actions on his wife's part, such as her failure to put her arms around him, or to kiss him occasionally. He felt that his wife had never forgiven him for an incident four years ago when he was "casually" embracing the family's housekeeper. Much of the patient's feeling of rejection seemed to be connected with his feelings of failure as a sexual partner for his wife.

The impression at intake was that "there is an infantile way about him which demands gratification and which he feels he is not getting and becomes something of a bad boy."

The diagnosis was "Psychoneurosis, mixed type, with gastric manifestations." A treatment plan was formulated to 1) examine the demands the patient made on his wife, and the reasons for his extra-marital wishes, and 2) to use the relationship with the therapist to point out the patient's demanding, but obedient attitude.

Description of Treatment:

The patient was seen in 23 interviews over a six-month period. He was continually late to interviews,

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The patient, a 37 year old man, was employed as a truck driver. He was married, and had five children. The family lived in a comfortable suburban community, in a seven room house.

The patient came to the clinic shortly after a period of observation at a state hospital following a court charge of assault and battery and lewdness toward a six-and-a-half year old girl. At the time of intake, he was on six month's probation. The patient said that he was innocent of this charge, but "had to plead guilty to keep the little girl out of court."

The patient presented the problem of his relationship to his wife. He felt continually that she was rejecting him, although he felt that his own feelings were "too easily hurt." He mentioned that he felt rejected at very slight actions on his wife's part, such as her failure to put her arms around him, or to kiss him occasionally. He felt that his wife had never forgiven him for an incident four years ago when he was "casually" embracing the family's housekeeper. Much of the patient's feeling of rejection seemed to be connected with his feelings of failure as a sexual partner for his wife.

The impression at intake was that "there is an infantile way about him which demands gratification and which he feels he is not getting and becomes something of a bad boy."

The diagnosis was "psychoneurosis, mixed type, with caustic manifestation." A treatment plan was formulated to 1) examine the demands the patient made on his wife, and the reasons for his extra-marital values, and 2) to use the relationship with the therapist to point out the patient's demanding, but obedient attitude.

Description of Treatment:

The patient was seen in 23 interviews over a six-month period. He was continually late to interviews,

so that almost all interviews were conducted in a one-half hour period. The patient was treated by a male casework student over a six-month period.

During the first ten interviews, the patient's situation remained relatively unchanged. Generally he expressed hostility to a number of people; specifically he was angry at his mother because of the demands she placed upon him. The patient described her as having remarried when the patient was three years old, but again was divorced after having a number of extramarital relations. She demanded funds from the patient, and he turned his pay over to her until he was about 28 years old. Since his marriage, the patient still was giving her money, although gradually he had decreased the amount, to his mother's consternation.

A similar demand situation toward which the patient was hostile was his job and his boss. The patient felt that the demands were unnecessary (overtime, physical labor, etc.), while the patient interpreted his boss's actions as hostile to him.

Also, the patient was able to verbalize his feeling of being overwhelmed by the financial demands of his large family, and was anxious about losing his job. He had developed feelings of fatigue, and therefore found it difficult to get to work on time. He also slept a great deal at home, although there was little physical reason for his fatigue. Throughout this period, although the worker tried to explore his specific feelings toward his wife, the patient continually denied almost all hostility to her.

In the eleventh through fourteenth hour, the patient's symptoms became more intense. He developed spots before his eyes, and his vision was blurry while he was having periods of indigestion. The patient continued to express anger toward his boss and work situation. He made slight mention of the fact that his wife did not call him "darling", but quickly blamed himself for this. In connection with this, he mentioned how his symptoms had been less intense during his time at the state hospital, and how helpful this experience had been for him.

The fifteenth through nineteenth hours were marked by the worker's attempt to clarify the relationship between himself and the patient. The patient seemed to gain some insight through a discussion of his lateness, seeing this as an attempt to run away from his

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problems. The patient related this to his attempts to run away from his problems earlier with his mother, and also saw that he tended to bring out other people's anger toward him by his attempts to keep from facing his problems. Finally the patient was able to discuss, in a rather limited way, some of his resentment of his wife, saying that he resented her adequacy and ability, which made him feel inferior. The patient began to see some of his general pattern of passivity. During this period the patient tended to come to interviews on time more often, or try to explain his lateness to the worker. At the nineteenth interview, the worker explained that he was leaving the agency and that plans must be made either for termination or continuation with another worker.

The rest of the contact tended to be a recuperative period, in which the patient lost his symptoms and felt relatively comfortable at home. He became more aggressive (in a socialized way) at work, and similarly took a more aggressive role at home. He gained weight, was able to take a positive stand with his mother, refusing to give her money unless she stopped gambling, and made some plans for a future move to another state in order to increase his income. The only remaining symptom at termination was the patient's need to sleep a great deal.

Discussion:

The patient's passive, aggressive personality became more evident in the process of treatment. This was involved in the worker-client relationship, particularly in terms of the lateness. The patient's hostility seemed to be channeled outside of the sexual area during treatment.

With the principle of abreaction, the worker was able to clarify much of the patient's general personality pattern of passivity and hostility. However, the patient continued to have difficulty expressing many of his feelings toward his wife.

Discussion:

The patient was never able to handle his hostile feelings toward the worker, in spite of the focus of the worker during one period upon the tardiness, and what this meant. The patient very quickly moved around this to the clarification of his need to run away from his problems. There may have been a strong need to please the worker, be dependent upon him, and consequently the patient may have been anxious about his hostility toward him.

Follow-up Interview:

The patient is seen at his home, a comfortably-built house whose furniture shows the results of the five children. The investigator is able to see the patient alone, although his wife is probably within hearing distance. The patient is rather sloppily dressed, since he didn't expect to see the investigator at this time, having forgotten the date of his coming.

The patient gives a rather guarded impression. He appears anxious in the interview.

The patient feels that although treatment helped him, the greatest help he received was at the state hospital before treatment, when he lost his symptoms. At present, all the symptoms seem to be at about the same intensity as at intake at the clinic (sexual attacks upon children, indigestion, fatigue). The patient feels that these symptoms return periodically, and that the remission at the termination of treatment was another such periodic occurrence. The patient feels that indigestion and fatigue occur when he is angry about something, but does not tell the investigator specifically what makes him angry, although he does express some resentment of his job. However, the knowledge of the connection of the anger and the physical symptoms doesn't seem to help the patient to fight off his symptoms.

The patient is very guarded and anxious about sexual material, and the investigator does not ask about this in detail.

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In discussing his family relationships, the patient denies anything but positive feelings. His children are his "life," while his wife is "wonderful." In fact, the patient says, "My wife can tell you much more about me than I can," and encourages the investigator to talk to her, rather than himself, although this is not done.

The patient feels that termination occurred because "My time was up, and they knew everything they needed to." There is no mention of his own part in this process.

The patient's financial situation is somewhat improved, since he has changed jobs and consequently receives better pay since clinic contact.

The patient is considering, at his wife's request, returning for further treatment, and wonders "if they'll take me again."

Discussion:

Although the patient evidently has some intellectual insight into the relationship of hostility to the development of his physical symptoms, there is almost no change in any area of reaction from the problem presented at the clinic at intake.

Most noticeable here is the degree of passivity that the patient presents. This is evident in his discussion about termination and returning for treatment, and particularly striking in his wish that his wife talk to the investigator.

The patient denies throughout the interview almost all negative feelings, except those toward his job.

Again, the sexual area seems difficult to approach, and this is probably partly a result of the proximity of his wife to the interview. However, the impression is definitely of

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extreme anxiety about sexuality in general, with accompanying feelings of guilt.

Case 6:

The patient was a 47 year old woman who was separated from her husband, and living with her mother and two nieces in a three room apartment in a housing project. She had a grown son who did not live with her.

The patient's family had a long history of mental illness, and the patient herself had had two hospitalizations for psychotic episodes. The patient was presently unemployed.

The patient came to the clinic with a number of problems. First, she was hostile toward her mother, which she traced to her finding her in a "compromising position" when she was a child. The patient felt that the mother had always made her life difficult by berating her to others, and thus bringing about other people's dislike of the patient. The patient told a similar story about her job history. The patient was never able to hold a job for more than six months, after the repetitive pattern of a woman boss or co-worker accusing her often of sexual promiscuity. The patient was vague as she talked about her need to fight her "wrong thoughts," and felt that this was the result of hormone injections which she received for her mental illness. The patient guardedly mentioned "numbers" as being important to her.

The diagnosis was "Schizoid personality marked by paranoid traits."

Psychological testing was requested to "evaluate the degree of her paranoid state as well as what evidence there is of strong homosexual conflicts." The Rorschach Test disclosed that "the patient seems to be a paranoid schizophrenic with a well-organized system of delusions who puts up a relatively good front of reality testing and conventional thinking. She is cautious, hostile, and suspicious, and tends to break out sporadically in violent emotional outbursts, probably aggressive in nature. There is some evidence of homosexual conflict as the basis for her paranoid ideas."

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Case 6:

The patient was a 17 year old woman who was separated from her husband, and living with her mother and two nieces in a three room apartment in a housing project. She had a grown son who did not live with her.

The patient's family had a long history of mental illness, and the patient herself had had two hospitalizations for psychotic episodes. The patient was presently unemployed.

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A treatment plan was formulated in which the first phase would consist of complete acceptance by the worker, including acceptance of the delusional material. Following this, it was planned to clarify the patient's own part in her problems, using the patient's attitude toward the worker as a tool to make this clarification emotionally real to the patient.

Description of Treatment:

The patient was treated by a female casework student in nine interviews which were very scattered over a six month period.

Generally, the first four interviews were marked by the patient's testing of the worker. The patient felt that the worker was the only person who understood her, and at the same time told about her own punishing attitude toward her niece. A great deal of projective material was discussed. The patient spoke of her husband "railroading" her into a mental hospital, and the difficulty they had had in the marriage as a result of his promiscuity. At the same time, the patient told about her difficulties in jobs where she had been charged with promiscuous behavior. The patient mentioned her difficulties with her mother, mentioning fights between the two marked by physical struggle. She looked to the worker for a decision as to whether or not to leave her mother and niece. The worker focused on the quarrels being a result of both the patient's and the mother's feeling, and the patient seemed to come to see some of her own role in the difficulty. During this time, the patient came regularly for interviews.

The patient's next interview occurred after a month and a half absence, after repeated letters from the worker inviting the patient to return. The patient spoke of her pleasure at the worker's interest, although the worker felt that the patient was denying a great deal of her fear and hostility about coming. The patient discussed her marital situation, and her anger about her husband's desertion. She had been able to receive alimony from him in the interim between interviews. The patient was also angry that her son did not write her, but only wrote her husband. The patient had quit her last job and was planning to return to work, after she had had to care for her mother, who was sick. The patient brought out that a similar situation to her own had occurred when her father had

deserted her mother.

Following interviews were very scattered. The patient discussed some of her feeling that the worker did not accept her, or believe her story about hormone injections causing her illness. The patient had tried to stop her physical struggles with her mother, but had only been partially successful. The worker explored some of her anger, and the patient was able to verbalize some of her underlying fear of her mother, and of other people.

The patient's scattered visits to the clinic were discussed in relation to the patient's fear of dependence on the worker. The worker commented that the patient had a tendency to idealize others to escape her fear of them, but only became disappointed in them in the process, and related this theme to a number of inter-personal incidents the patient had mentioned.

In the last two interviews, the patient consistently denied her own part in her problem, and could only blame her mother, husband, fellow-workers, etc. Consequently, she became hostile to the worker for "not believing me." The patient was continuing to have difficulty in her jobs. During this period, the worker informed her of her own leaving. The patient never returned following this.

Discussion:

The worker herself commented that although the patient was discharged improved, the movement here was very slight. The worker felt that the patient's "acting out" had become less violent, and that perhaps the patient had acquired some intellectual insight into her own role in her problems. However, it may be seen that at the end of the contact, the patient's regression seems to have continued.

The primary principle here seems to be clarification on an intellectual basis. The patient did not seem ready for such a focus, and her ambivalence toward the worker was never

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worked through, so that the patient was driven from treatment.

Follow-up Interview:

The patient was seen at her mother's home, an apartment in a housing project. The patient had moved away from her in the interim. The interview was conducted after a great deal of action on the patient's part before the contact. The patient had telephoned the clinic on a number of occasions, and finally had written a long letter to arrange the time and place of meeting, which demonstrated very strong ambivalence about the interview. The letter went into detail about the patient's feelings about research interviews in general, which the patient called "testing for emotional balance under pressure."

The interview was conducted in a room adjacent to where the patient's mother was sitting, with the door open. The patient said that her mother "couldn't hear," and spoke very loudly in the interview at all times, particularly when speaking of her mother's failings.

The patient's hostility toward a number of objects was evident in the interview, although it was characterized by an anxious smile.

Much of the pattern of reaction seems to be the same with the patient. She mentioned that she had had six jobs since leaving the clinic, and was about to leave her present place of employment, where she was working as a secretary. Delusional material was still very evident although there had been some change in focus, and rather than telling about others' accusations toward her of promiscuity, the patient mentioned rather vaguely a plot by the F.B.I. in collaboration with social workers to tell her employers about her hospitalization, which had been brought about by "hormone injections." The hostility of the patient toward her mother, husband and son seemed to continue unabated.

The patient felt that treatment was helpful to her, and mentioned "learning that I have a part in my work troubles," but moved quickly to justifying her anger.

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Discussion:

The patient offers a very similar picture of herself to that gained at clinic intake. It is the writer's guess that the patient continues to "act out" as violently as she did at that time. Judging from the violence of the follow-up interview, the insight gained from treatment seems to have had very little effect on her behavior.

Noticeable is the possible shift away from sexual trends in the patient's delusions.

Case 7:

Diagnostic Considerations:

The patient was 38 years old at intake. She had been married for 13 years, and lived with her husband, son, age seven, and daughter, age two, in a six-room single home. She was slightly deaf.

The patient dated her difficulty to 18 years previous to intake when her sister died in childbirth, and the patient began to fear her own death in a similar situation. Two years later, a boyfriend died of an embolism, and the patient began to fear dying again. As a result of this, she spent a year in therapy elsewhere.

The patient found after marriage that she was unable to conceive, although no organic reason for this could be found. The patient developed an intense desire for a child.

Six years before, the patient's father died, and again the patient feared her own death, dating this time as the beginning of the intensive obsession. At about the same time the patient adopted her son, but after this concluded that she really did not want a child. However, she became pregnant with her daughter, which intensified her obsessive fear of death. The patient was depressed after the delivery, most often in the morning. At the same time, the patient "lost interest" in intercourse, and performed this "only as a

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duty."

The patient impressed the staff at intake with her apparently intelligent attitude and eagerness for help.

She was diagnosed "Phobic reaction with obsessive fear of death." Psychological testing was recommended, "to determine, if possible, the basis for her fear of death, and in this connection, to determine the fantasies related to her ideas about her father and her husband." The T.A.T. did not provide conclusive data about this, but showed "a very strong desire to conceal a part of herself which she consciously or unconsciously knows to exist." The clearest production was the emotional lability that the patient displayed. However, the psychologist cautiously stated, "the patient's overt sorrow over the death of her father is probably superimposed over latent death wishes toward him, which are too guilt-provoking for the patient to accept freely on her consciousness, though she seems not wholly unaware of them, and her phobia about death is probably a fear of retribution for her wickedness."

A treatment plan was formulated to help the patient to grieve for her dead father, to help her resolve what appeared to be unresolved guilt with respect to his death and the fear that she might be similarly punished.

Description of Treatment:

The patient was treated by a female staff caseworker in three interviews over a month. During this time, the worker explored the patient's fear of death. The patient denied any connection between this and the death of her father. She mentioned the theme of "giving without getting" as related to her fears and such physical symptoms as tightness in her throat, heart palpitations, etc. Finally, the worker pointed out that the fears were at their worst in the morning, and that the worst day was Sunday. The patient noticed that her father had died on Sunday morning. The patient never returned after this admission, but called the worker two and a half months later to relate that she wanted to leave treatment, since her relatives did not want her to continue. She felt that she had had "a few good days."

Discussion:

The primary principle used here seems to be interpretation,

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Follow-up Interview:

The patient is seen at home. The house, in which the patient was living at the time of treatment, tends to belie the low income she presented at intake, since it is a large, comfortable suburban home.

The patient is a too-youthfully dressed woman with bleached hair and slacks, whose behavior is superficially friendly, but is extremely aggressive, although she seems genuinely warm with her children.

The patient had not expected the investigator at this time, thinking that he was to come the following week.

Much of the interview is spent in the patient's discussion of psychiatry generally. She is quite sophisticated in this subject, and obviously takes pride in her knowledge. The patient asks the investigator's profession, and then mentions that "only a psychiatrist can really help a disturbed person." In connection with this the patient attacks her caseworker, saying, "She was really too young to understand, and although she was nice, I question how much knowledge she had of psychiatry."

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The patient left treatment because of this feeling, although her symptoms had not diminished. She returned to private therapy, which she described as a supportive relationship, although she was angry at her psychiatrist

for his high fees and apparent lack of interest in her. Therapy was carried on for eight months in one-half-hour interviews every two weeks. The patient is remarkably ambivalent toward this therapist.

The patient's fear of death left gradually, and she feels much more relaxed now. However, her deafness has increased, which the patient feels is a result of an operation about a year ago. The patient has a lingering fear of daylight, although this is not intense.

The impression of the investigator is that the deafness is used as a way of dominating in the interview situation.

Discussion:

The writer finds it very difficult to evaluate the patient's movement. There is the factor of the additional therapy which the patient had after clinic treatment. Similarly, there is the question of a somatization of symptoms, indicating more regressed behavior. On the other hand, it is probable that the patient is less anxious at present than she was at the clinic, and seems more socially integrated.

Obviously, a great deal of pathology is still indicated. It is the writer's feeling that very little change of any kind resulted from the patient's contact with the clinic.

SECTION III - DESCRIPTION OF DIAGNOSIS, PRIMARY TREATMENT PRINCIPLE, AND IMPROVEMENT IN EACH CASE

Figure I indicates that the range of diagnoses in the presented cases was wide. Four of the seven cases demonstrated continuing improvement after a three year period away from treatment. The principle used most successfully in treatment

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was manipulation.

FIGURE I

DESCRIPTION OF DIAGNOSIS, PRIMARY TREATMENT PRINCIPLE, AND IMPROVEMENT IN EACH CASE

Case Number	Diagnosis	Primary Treatment Principle	Condition at Follow-up
1	Reactive depression, moderate	Manipulation	Moderate improvement
2	Schizoid personality	Clarification, with strong use of abreaction and manipulation	Moderate improvement
3	Psychoneurosis-anxiety state	Manipulation	Close to "optimal"
4	Anxiety state, mild	Manipulation	Moderate improvement
5	Psychoneurosis, mixed type	Manipulation	Unimproved
6	Schizoid personality, marked paranoid traits	Clarification	Unimproved
7	Phobic reaction, with obsessive fear	Interpretation	No conclusion

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CHAPTER V

SUMMARY AND CONCLUSIONS

In this study the writer undertook a follow-up study of seven cases treated by caseworkers at Briggs Clinic during 1951 for a period of six months or less. The aim was to evaluate the holding power of short-term casework service in a psychiatric setting. The cases studied were all discharged improved from the clinic. These cases represented one-half of the sample (all cases treated individually by caseworkers for less than six months in 1951). The follow-up was conducted on an interview basis, with the focus being upon the movement seen in the case recording concerning the patient in treatment.

The cases for which this study attempted to suggest answers were 1) In what ways does improvement seen by the clinic at discharge continue after a three year period without treatment at the clinic? 2) In what ways are casework treatment principles used in these cases? 3) What attitudes toward treatment are seen in the follow-up interviews?

The general conclusions offered in relation to the seven cases are as follows:

1. A good deal of continuing improvement was seen in the follow-up interviews. This was particularly evidenced in relation to patients' social, rather than psychic adjustment, where rechanneling of motivation occurred as movement toward

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1. A good deal of continuing improvement was seen in the follow-up interviews. This was particularly evidenced in relation to patients' social, rather than psychic adjustment, where reclamming of motivation occurred as movement toward

more integrated social behavior. Basic problems and needs were not radically effected by treatment, although the ways of handling these were altered. For example, Case One came to channel the satisfaction of some of her aggressive needs outside of her marital situation with resultant increased satisfying work activities.

Treatment acted as a basis for continuing extended improvement away from treatment in some cases, while other patients remained at the same level seen at discharge. Although improvement was relatively moderate in scope, decided gains in increased satisfactions were seen.

A direct cause-and-effect relationship between improvement and treatment was not always evident, since other factors in the environment, integrated with gains made in treatment, aided in continuing movement over the three year period. Thus, Case Three continued further movement after treatment as his financial situation was somewhat relieved.

Short-term treatment was seen to be effective with a variety of diagnoses.

Follow-up interviews demonstrated some further pathology, indicating that further treatment might be of value. While Case Four showed renewed ability in making gains in independent action, continued ambivalence toward her children and husband was still evidently a problem in her family relationships, thus illustrating this observation.

In cases of little continuing improvement, presenting

attitudes toward treatment and termination problems did not appear to have been worked through. This was evidenced in Case Five, where the underlying problem of passivity, both in treatment and in family relationships, interfered with the patient's full participation in leaving the clinic.

However, in spite of the relatively narrow scope of short-term treatment, it was indicated that this treatment was used with varying diagnoses to advantage.

2. All principles of casework treatment were seen to be involved in short-term treatment. However, manipulation, as defined in this study, seemed to be used predominantly in cases of continuing improvement. Other principles were used to intensify the manipulative experience for the client. All cases showing improvement in the follow-up indicated this, with the exception of Case Two, where clarification as a primary principle was used in combination with intense use of manipulation and abreaction.

3. Most patients showed some positive attitude to the clinic experience, whether or not they were disappointed in treatment. Ambivalence was involved in attitudes toward both the follow-up interview and the clinic. This was expressed by forgetting the follow-up interview time, but being available when the investigator called, and in both positive and negative feelings about treatment and the staff.

Very little insight, either into the patients' own problems or the treatment process was displayed, whether or not

improvement had continued. Thus, Case Three could not characterize treatment beyond saying that it was a soothing process, and gave a great deal of credit to factors outside of treatment, although his symptoms had actually radically diminished in treatment.

Patients tended to feel that they had been helped by the clinic, whether or not the investigator saw evidence for continued improvement. Case Six, although showing virtually the same behavior patterns that were causing her difficulty at clinic intake, credited treatment as being helpful to her, although her reactions were virtually the antithesis of what she had "learned" in treatment.

Approved:
Richard K. Conant
Richard K. Conant
Dean

A P P E N D I X

APPENDIX

ADDITIONAL INFORMATION ON TWO CASES:

In the course of studying the material, the writer received some information on two additional cases, although it was impossible to conduct personal interviews. The writer feels that this information might throw some further light on the subject discussed.

The first patient, a 51 year old woman, diagnosed "anxiety state" had come to the clinic with feelings of tension accompanied by some physical symptoms. Much of the conflict seemed to center around the patient's loss of her husband, who had divorced her. The caseworker helped her to express her feelings around this loss in seven interviews, and felt that the patient was somewhat more cheerful and energetic at termination. The patient moved away from the area of the clinic. The writer received a letter from the patient which said, in part:

> I do believe that I received some help at the clinic although I still have the tension, and the constant feeling of tiredness. I think it does prove helpful to have some qualified person to talk to, and if I were still a resident of Boston, would continue with my visits.

The second patient, a 19 year old girl, diagnosed "anxiety reaction," complained at intake of nausea, stuttering, lack of appetite, and general tension, relating to normal teen-age social contacts. It was seen that this reaction was ultimately related to her feelings of guilt about the recent marital break-up of her parents, which in turn related to her feelings

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about her father.

The patient was seen in fourteen interviews, and terminated after her caseworker's summer vacation. It was seen that the patient's symptoms had diminished slightly, and the patient had become more active socially, after the worker had explored and accepted her sexual feelings toward her contemporaries, and her thoughts about the separation of her parents.

Although it was impossible for the writer to interview the patient in the follow-up, the patient's mother called the clinic to say that the patient had moved, and was presently "happily married."

FIGURE II

BREAKDOWN OF CASE STUDIES IN NUMBER OF INTERVIEWS AND TOTAL TREATMENT TIME*

Number of Interviews		Total Time in Treatment (app.)
Case 1	6	1 1/2 months
Case 2	8	3 "
Case 3	10	5 1/2 "
Case 4	13	6 "
Case 5	23	6 "
Case 6	9	6 "
Case 7	3	1 "

* Time is computed by the beginning and ending dates of treatment interviews, rather than from the actual time of the opening diagnostic interview to the closing date.

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FIGURE III

KEY TO CASES

Code Number	Agency Number
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3	51-319
4	50-116
5	50-233
6	50-218
7	50-212
Additional cases	51-376
	51-338

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THE COMMONWEALTH OF MASSACHUSETTS

The Briggs Clinic
895 Blue Hill Avenue
Boston 24, Massachusetts
Geneva 6-2604

Dear

In order that we may evaluate our work at the Briggs Clinic, we are conducting a research survey among former patients. In connection with this survey, I would like to see you at your home on

You will be performing a valuable service if you will talk to us about your reactions to treatment.

While the Clinic is always interested in all its patients, both those who have terminated as well as those who are still in treatment, this survey is not an attempt to have you return for treatment, but rather to discover how well we have served our patients.

If you feel it might be difficult to discuss treatment at your home, will you please fill out the enclosed form and return it to the Clinic as soon as possible?

Thank you for your cooperation and help.

Sincerely yours,

Robert Rice
Social Service Department

RR:imh
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( ) I would rather talk to you at the Clinic. Will you send me an appointment on

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Date preferred. (see note below for available hours)

( ) I would rather see you at

_____
Address

at _____, rather than at the Clinic
Date and time preferred

or at home.

( ) Although I cannot see you at home on the date you mentioned in your letter, I can see you at home on

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Date preferred

Available Hours:
Monday through Friday 9 A.M. to 5 P.M.
2nd and 4th Wednesday of the month until 8:30 P.M.

( ) I would rather talk to you at the clinic. Will you send me an appointment on

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SCHEDULE

I. Diagnostic Considerations

1. Identifying Information
   a. Age
   b. Sex
   c. Marital Status
   d. Living Conditions
   e. Presenting Attitude
   f. Presenting Problem and Onset

2. Diagnosis and Psychologicals (if any)

3. Treatment Plan

II. Description of Treatment

1. Identifying Information
   a. Status of Caseworker
   b. Number of Interviews
   c. Continuity of Interviews

2. Areas of Movement

3. Caseworker's Evaluation

4. Termination
   a. How Terminated?
   b. Who Initiated Termination?

5. Principles of Casework Used

III. Follow-up Interview

1. Identifying Information
   a. Living Conditions
   b. Description of Patient
   c. Attitude toward Interviewer and Follow-up

2. Continuing Improvement
   a. Socio-economic
   b. Psychic
   c. Familial

3. Attitude toward Treatment

4. Insight
   a. Into Problem
   b. Into Treatment Process

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